

12VAC30-50-100. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; enrolled providers.

A. Preauthorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and freestanding psychiatric hospitals. Nonauthorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS). Preauthorization shall be based on criteria specified by DMAS. In conjunction with preauthorization, an appropriate length of stay will be assigned using the HCIA, Inc., Length of Stay by Diagnosis and Operation, Southern Region, 1996, as guidelines.

1. Admission review.

a. Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

b. Unplanned/urgent or emergency admissions. These admissions will be permitted before any prior authorization procedures. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions which have been determined to be appropriate. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

2. Concurrent review shall end for nonpsychiatric claims with dates of admission and services on or after July 1, 1998, with the full implementation of the DRG reimbursement methodology. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued inpatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient from acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

3. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for these services. Adverse authorization decisions shall have available a reconsideration process as set out in subdivision 4 of this subsection.

4. Reconsideration process.

a. Providers requesting reconsideration must do so upon verbal notification of denial.

b. This process is available to providers when the nurse reviewers advise the providers by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he disagrees with the nurse reviewer's findings. If higher level review is not requested, the case will be denied and a

denial letter generated to both the provider and recipient identifying appeal rights.

c. If higher level review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a decision. If the UMS upholds the adverse decision, the provider may accept that decision and the case will be denied and a denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he must request physician review by DMAS medical support. If higher level review is requested, the authorization request will be held in suspense and referred to DMAS medical support for the last step of reconsideration.

d. DMAS medical support will review all case specific medical information. Medical support shall have two working days to render a decision. If medical support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.

5. Appeals process.

a. Recipient appeals. Upon receipt of a denial letter, the recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, Part I (12VAC30-110-10 et seq.) of 12VAC30-110, the recipient shall have 30 days from the date of the denial letter to file an appeal.

b. Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be held in accordance with the Administrative Process Act (§9-6.14:1 et seq. of the Code of Virginia).

B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the pre-authorization requirements specified in subsection A above, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

4. It is general practice for recipients in a particular locality to use medical resources in another state.

~~B. C.~~ C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

~~C. D.~~ D. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.

~~D. E.~~ E. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be authorized for payment. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically indicated. Except as previously noted, regardless of authorization for the hospitalization, the claims will be processed in accordance with the limit for 21 days in a 60-day period. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days for nonpsychiatric admissions shall cease with dates of service on or after July 1, 1998.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric hospitals in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent or retrospective review processes described in subsection A of this section. Medically unjustified days in such hospitalizations shall not be authorized for payment.

Ε. F. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

Ε. G. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

Ε. H. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma or breast cancer. Transplant services for liver, heart, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow transplant/stem cell services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or

pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-570.

¶ I. (Reserved.)

¶ J. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review. Hospitals must submit the required DMAS forms corresponding to the procedures. Regardless of authorization for the hospitalization during which these procedures were performed, the claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

12VAC30-50-105. Inpatient hospital services provided at general acute care hospitals and freestanding psychiatric hospitals; nonenrolled providers (nonparticipating/out of state).

A. The full DRG inpatient reimbursement methodology shall become effective July 1, 1998, for general acute care hospitals and freestanding psychiatric hospitals which are nonenrolled providers (nonparticipating/out of state) and the same reviews, criteria, and requirements shall apply as are applied to enrolled, in-state, participating hospitals in 12VAC30-50-100.

B. Inpatient hospital services rendered by nonenrolled providers shall not require ~~preauthorization~~ prior authorization with the exception of transplants as described in subsection K of this section and this subsection B. However, these inpatient hospital services claims will be suspended from automated computer payment and will be manually reviewed for medical necessity as described in subsections ~~C~~ B through K of this section using criteria specified by DMAS. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia shall only be reimbursed under at least one of the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization.

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is general practice for recipients in a particular locality to use medical resources in another state.

C. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under four days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed three days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection H of this section.)

D. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

E. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus was carried to term.

F. Hospital claims with an admission date prior to the first surgical date, regardless of the number of days prior to surgery, must be medically justified. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for all pre-operative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

G. Reimbursement will not be provided for weekend (Saturday/Sunday) admissions, unless medically justified. Hospital claims with admission dates on Saturday or Sunday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admission will be denied.

H. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis or treatment plan. The 60-day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days for the same or similar diagnosis or treatment plan will not be reimbursed. Claims which exceed 21 days per admission within 60 days with a different diagnosis or treatment plan will be considered for reimbursement if medically justified. The admission and length of stay must be medically justified and preauthorized via the admission and concurrent review processes described in subsection A of 12VAC30-50-100. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease with dates of service on or after July 1, 1998. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21

YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age who are Medicaid eligible for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination.

I. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

J. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the DMAS outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions.

K. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma or breast cancer. Transplant services for liver, heart, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-570.

L. Coverage of observation beds. (Reserved.)

M. In compliance with 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

12VAC30-50-140. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Outpatient psychiatric services.

1. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to DMAS' approval) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by DMAS. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. Consistent with §6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary psychiatric services shall be covered when prior authorized by DMAS for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening.

2. Psychiatric services can be provided by psychiatrists or by a licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric under the direct supervision of a psychiatrist.*

3. Psychological and psychiatric services shall be medically prescribed treatment which is directly and specifically related to an active written plan designed and signature-dated by either a psychiatrist or by a licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric under the direct supervision of a psychiatrist.*

*Licensed clinical social workers, licensed professional counselors, and licensed clinical nurse specialists-psychiatric may also directly enroll or be supervised by psychologists as provided for in 12VAC30-50-150.

4. Psychological or psychiatric services shall be considered appropriate when an individual meets the following criteria:

- a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels which have been impaired;
- b. Exhibits deficits in peer relations, dealing with authority; is hyperactive; has poor impulse control; is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, ability to learn, or ability to participate in employment, educational, or social activities;
- c. Is at risk for developing or requires treatment for maladaptive coping strategies; and
- d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

5. Psychological or psychiatric services may be provided in an office or a mental health clinic.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus was carried to term.

G. Physician visits to inpatient hospital patients over the age of 21 are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses or treatment plan and is further restricted to medically necessary authorized (for enrolled providers)/approved (for nonenrolled providers) inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days shall be limited to medically necessary inpatient hospital days.

H. [Reserved.]

I. Reimbursement shall not be provided for physician services provided to recipients in the inpatient setting whenever the facility is denied reimbursement.

J. [Reserved.]

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma or breast cancer. Transplant services for liver, heart, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-570.

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If prior authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized, for all medically necessary indications. Such procedures shall be considered noncosmetic.

2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated or are intended solely to preserve, restore, confer, or enhance the aesthetic appearance of the breast.

M. Coverage of out-of-state inpatient hospital services. Inpatient hospital services

provided out of state to a Medicaid recipient who is a resident of the state of

Virginia shall only be reimbursed under at least one the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is general practice for recipients in a particular locality to use medical resources in another state.

12 VAC 30-60-21. Utilization control of non-participating out-of-state inpatient hospitals. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia shall only be reimbursed under any one of the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization. It shall be the responsibility of the admitting physician to adhere to these restrictions. Services provided out of state for circumstances other than these specified exceptions shall not be covered. When, during post payment utilization review, inappropriate or inaccurate payments are determined to have been made for reasons other than those specified herein, DMAS shall recover the inappropriately expended funds.

- A. The medical services must be needed because of a medical emergency;

- B. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

- C. The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

- D. It is general practice for recipients in a particular locality to use medical resources in another state.

12VAC30-70-120. Nonenrolled providers. Repealed.

~~A. Hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the lesser of:~~

~~1. The DMAS average reimbursable inpatient cost to charge ratio, updated annually on September 30 of each year based on the most recent settled cost report, for enrolled hospitals less 5.0%. (The 5.0% is for the cost of additional manual processing of the claims.)~~

~~2. The DMAS average per diem, updated annually on September 30 of each year based on the most recent settled cost report, of enrolled hospitals excluding the state-owned teaching hospitals and disproportionate share adjustments.~~

~~B. Hospitals that are not enrolled shall submit claims using the required DMAS invoice formats. Such claims must be submitted within 12 months from date of services. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospital's financial fiscal year. A hospital which is required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in 12VAC30-70-10 through 12VAC30-70-100. The hospital shall be placed in one of the DMAS peer groupings which most nearly reflects its licensed bed size and location (12VAC30-70-50 A). These hospitals shall be required to maintain separate cost accounting records and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).~~

~~C. A newly enrolled facility shall have an interim rate determined using the provider's most recent filed Medicare cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates shall be determined in accordance with the current Medicaid Prospective Payment System as noted in subsection A of this section.~~

~~D. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status to receive reimbursement. If an enrolled provider elects to terminate the enrolled agreement, the nonenrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.~~

~~E. Prior approval must be received from DMAS when a referral has been made for treatment to be received from a nonenrolled acute care facility (in state or out of state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.~~

~~F. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services,~~

~~such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for the services on an individually negotiated rate basis.~~

12VAC30-70-420. Reimbursement of nonenrolled general acute care hospital providers.

During the transition period, nonenrolled general acute care hospitals (general acute care hospitals that are not required to file cost reports) shall be reimbursed according to the previous methodology for such hospitals (12VAC30-70-120 A). Effective with discharges after June 30, 1998, these hospitals shall be paid based on DRG rates unadjusted for geographic variation. General acute care hospitals shall not file cost reports if they have less than 1,000 days per year (in the most recent provider fiscal year) of inpatient utilization by Virginia Medicaid recipients, inclusive of patients in managed care capitation programs.

Prior approval must be received from DMAS when a referral has been made for treatment to be received from a ~~nonenrolled non-participating~~ acute care facility (in-state or out-of-state), ~~except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state~~. Prior approval will be granted for inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia under any one the following conditions. It shall be the responsibility of the non-participating hospital, when requesting prior authorization for the admission of the Virginia resident, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out of state for circumstances other than these specified reasons shall not be covered.

- A. The medical services must be needed because of a medical emergency;

- B. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

- C. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

D. It is general practice for recipients in a particular locality to use medical resources in another state.

CERTIFIED:

March 28, 2000
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services